STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
ACRAMENTO, CA 95814
(916) 445-1912

October 14, 1982

To: ALL COUNTY WELFARE DIRECTORS Letter No. 82-53

MONTHLY SHARE OF COST (SOC) MANDATE

Reference: CWD Letters No: 81-51, 81-39, and 82-6

As you are aware, SB 1326 (Chapter 327, Statutes of 1982) requires the use of a monthly SOC determination for all Medi-Cal recipients. SB 2012 (Chapter 1594, Statutes of 1982) specifies that regulations to implement this provision be filed on an emergency basis. This letter is to provide you with sufficient information to begin planning for the return to a monthly SOC determination from the multi-month determination. Implementation of the change shall occur beginning October 1, 1982 for intake cases and the November month of eligibility for continuing cases.

Attached are the copies of the regulations to implement monthly SOC filed with an effective date of October 1, 1982. Also attached is an advanced copy of revisions to the Procedures Manual dealing with SOC. (Please note that the Procedures Manual will need to be revised again when monthly SOC forms are available.)

CONVERSION METHODOLOGY

1. Conversion of the existing caseload to a monthly SOC is to begin for the November month of eligibility. The conversion can be staggered over the November and December, 1982 and January 1983 period as long as by February 1, 1983, all cases have their SOCs determined on a monthly basis. However, conversion of a continuing case is to be made no later than the time the existing multi-month SOC period ends within this November-January period. For example, if a recipient's quarterly SOC period is August, September and October, that recipient's SOC must be converted to a monthly basis as of November. Similarly, if a recipient's QSOC period ends in November, that recipients's SOC for December and ongoing is to be on a monthly basis. This does not mean, however, that counties are to be required to immediately convert cases which were assigned a QSOC for the November-January period before receipt of this letter and, if appropriate, had been sent timely and adequate notice.

2. SOC determination for intake cases in October, 1982 and ongoing are to be computed on a monthly basis. If retroactive benefits also are requested, that SOC also is to be computed on monthly basis, even if the retroactive period is prior to October, 1982.

FORMS

We are in the process of printing a supply of monthly SOC determination forms. You will be informed when they can be ordered from the warehouse. If such forms are not available to your county by the time of conversion, you may use either (1) the MC 176M 9/81 SOC Determination -- MFBUs Which Do Not Include LTC Persons or (2) the MC 176M-LTC 9/81 SOC Determination -- MFBUs LTC Person Included.

NOTICES OF ACTION

Notices of Action are to be sent to all recipients who have a share of cost. Although the conversion from a quarterly SOC to a monthly SOC is not by itself an adverse action, recipients have a right to a fair hearing on the issue of the compution of the monthly SOC. Therefore, the Notice of Action explaining the conversion and specifying the SOC amount must be timely as well as adequate.

STUFFERS

Recipients without a SOC may be sent stuffers instead of Notices of Action since the conversion to a monthly SOC does not meet any condition requiring a Notice of Action as outlined in Eligibility and Assistance Standards Manual Section 22-021.

SYSTEMS CHANGE FUNDING/COUNTY ADMINISTRATIVE COSTS

The Legislature did not appropriate any funds for FY 82-83 for either conversion back to monthly SOC or for costs for continuing multi-month SOC until the conversion. Any allocation adjustments for multi-month SOC will not be possible until the end of FY 82-83 when we can determine available funding.

If you have any questions, please contact your Medi-Cal Program Consultant at (916) 445-1912.

Sincerely,

Original signed by

Madalyn M. Martinez, Chief
Medi-Cal Eligibility Branch

Attachment

cc: Medi-Cal Liaisons
Medi-Cal Program Consultants

FACE SHEET
FOR FILING ADMINISTRATIVE REGULATIONS
WITH THE OFFICE OF ADMINISTRATIVE LAW

R-64-82

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1. The attached are true and correct copies of regulations adopted, amended, or repealed by:

DEPARTMENT OF HEALTH SERVICES
(Agency)

September 30, 1982
(Date)

By: Beverlee A Myers
(Agency Officer with Rule-Making Authority)
Beverlee A. Myers, Director

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AGENCY CONTACT PERSON AND POSITION — TELEPHONE NUMBER

Ron Wetherall, Chief, Office of Regulations — (916) 322-4990

2. Indicate California Administrative Code Title and specify sections to be amended, adopted, and/or repealed:

Title 22

Sections Amended: 50137, 50191, 50517, 50653, 50653.3, 50655.5, 50657, 50658 & 50737

Sections Adopted:

Sections Repealed: 50565, 50652

3. Type of Order:

a. ☐ Regular

b. ☒ Emergency (attach Finding of Emergency)

c. ☐ Other Regulatory Action:

- ☐ Certificate of Compliance
- ☐ Procedural and Organizational Changes
- ☐ Editorial Correction
- ☐ Authority and Reference Citation Changes

d. Check one: ☐ ALL ☐ SOME ☒ NONE of the regulatory changes in this order are the result of the agency's review of existing regulations (see instructions in Part 3(b) on reverse).

e. ☐ This order is a resubmittal of previously disapproved or withdrawn regulations.

f. These regulations ☐ DO ☒ DO NOT contain building standards as defined in Section 18909 of the Health and Safety Code.

g. ☐ These are Conflict of Interest regulations containing the FPPC approval stamp and:

- ☐ Are to be published in full in the Administrative Code.
- ☐ Are to be codified by appropriate reference in the Administrative Code. (Include a statement as to where the full text may be obtained.)

h. ☐ These are fire and panic safety regulations containing State Fire Marshal approval.

4. Effective Date of Regulatory Changes: 10/1/82

Government Code Section 11346.2 provides that a regulation is effective on the 30th day after the date of filing with the Secretary of State. If an exception is desired, see the instructions on reverse. Check the appropriate box and fill in the appropriate information below.

a. ☐ On _____ as required by statute: _____.

b. ☐ On _____ (Designated Effective Date later than 30 days after filing with the Secretary of State pursuant to Government Code Section 11346.2(d)).

c. ☐ On _____ (Designated Effective Date later than 30 days after filing with the Secretary of State).

(1) Amend Section 50137 by deleting subsection (a)(3).

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

(2) Amend Section 50191 by amending subsection (a) to read as follows and deleting subsection (c).

(a) The county department shall require the completion of a Medi-Cal Status Report, Form MC 176S, at three month intervals ~~as specified in (c)~~ for all MFBUs which contain at least one AFDC-MN or MI person. The requirement to complete status reports shall not apply to the following:

(1) through (5) unchanged.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(3) Amend Section 50517 by amending subsections (a)(2)(A) and (a)(4) and adding new subsection (a)(8) to read:

(A) The beneficiary wishes to receive Medi-Cal for more than two months ~~or the beneficiary is included in an MFBU with a multimonth share of cost period pursuant to Section 50652(a).~~

(4) Income received less frequently than monthly shall be converted to monthly income by the following methods ~~for MFBUs with a one-month share of cost pursuant to Section 50652(b).~~

(A) Divide quarterly income by three.

(B) Divide income received every two months by two.

(8) Interest income which is received less frequently than monthly and is not exempt as specified in Section 50542 shall be apportioned as follows:

(A) Determine the number of months of the period during which the interest accrued.

(B) Divide the interest income by the number of months in the interest period.

(C) Consider the amount determined in (B) as income in each of the months of the next interest period.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(4) Repeal Section 50565.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(5) Repeal Section 50652.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(6) Amend Section 50653(a) and (a)(1) to read:

(a) The share of cost shall cover a one month period and be determined as follows:

(1) For MFBUs which do not include a person in LTC:

(A) Determine the net nonexempt income ~~anticipated to be~~ available to the members of the MFBU ~~during each month of the share of cost period~~.

(B) Round the total net nonexempt income ~~for each month~~ determined in (A) to the nearest dollar, with amounts ending in 50 cents or more rounded to the next higher dollar. ~~Add these amounts.~~

(C) Determine the appropriate maintenance need for the MFBU ~~for each month during the share of cost period~~ in accordance with Section 50603. ~~Add these amounts.~~

(D) Subtract the combined maintenance need from the total rounded net nonexempt income ~~for the share of cost period~~. The remainder, if any, is the share of cost.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(7) Amend Section 50653.3, subsections (a) and (b) to read:

(a) In situations where a change in income or other circumstances, which results in a decrease in the share of cost is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

(1) Make the necessary changes in the ongoing share of cost by the first of the ~~share of cost period~~ month following the ~~period~~ month in which the change was reported.

(2) Determine what the share of cost should have been for the ~~share of cost period~~ month in which the change occurred.

(3) Implement the beneficiary's choise of either of the following:

(A) Having an adjustment made in future ~~share of cost periods~~ months in accordance with (c) for the ~~periods~~ months in which income in excess of the correct share of cost was paid or obligated toward medical bills.

(B) Having the correct form MC 177S or Medi-Cal card with a share of cost issued and processed for the ~~share of cost periods~~ months in which the share of cost should have been lower.

(b) In situations where a change in income or other circumstances, which results in a decrease in the share of cost, is not reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall:

~~(1)--For-MFBUs-with-a-one-month-share-of-cost-period:~~

~~(A)~~ (1) Make the necessary changes in the ongoing share of cost by the first of the month following the month in which the change was reported.

~~(B)~~ (2) Not make an adjustment for the excess income the beneficiary may have paid or obligated prior to county action specified in ~~(A)~~ (b)(1) unless the county department determines that there was good cause for failure to report in a timely manner. Good cause shall be determined in accordance with Section 50175.

~~(2)--For-MFBUs-with-a-multimonth-share-of-cost-period-and-the-change is-reported-during-the-last-month-of-the-period:~~

~~(A)--Make-necessary-changes-in-the-ongoing-share-of-cost-by-the-first of-the-following-share-of-cost-period:~~

~~(B)--Not-make-an-adjustment-for-the-excess-income-the-beneficiary may-have-paid-or-obligated-prior-to-county-action-specified-in-(A)-unless the-county-department-determines-that-there-was-good-cause-for-failure-to report-in-a-timely-manner:~~

~~(3)--For-MFBUs-with-a-multimonth-share-of-cost-period-and-the-change is-reported-prior-to-the-last-month-of-the-period:~~

~~(A)--Make-the-necessary-changes-in-the-ongoing-share-of-cost-by-the first-of-the-following-share-of-cost-period:~~

~~(B)--Determine-what-the-share-of-cost-should-have-been-for-the-share of-cost-period-in-which-the-change-occurred-by:~~

~~1:--Making-the-necessary-changes-effective-the-first-of-the-month, within-the-share-of-cost-period,-following-the-month-in-which-the-change~~

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~~was reported.~~

~~2.--Not making any adjusgments to reflect the changes in any month prior to the county action specified in 1, unless the county department determines that there was good cause for failure to report the change in a timely manner.~~

~~(6)--Implement the beneficiary's choice of either of the following:~~

~~1.--Having an adjustment made in future share of cost periods in accordance with (e) for the periods in which income in excess of the correct share of cost was paid or obligated toward medical bills.~~

~~2.--Having the correct Form MC 177S issued and processed for the share of cost periods in which the share of cost should have been lower.~~

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(8) Amend Section 50653.5 by amending subsections (a) and (b)(2) to read as follows and deleting subsection (c).

(a) In situations where a change in income or other circumstances, which results in an increase in the share of cost, is reported by the beneficiary in a timely manner, as specified in Section 50185, the county department shall make necessary changes effective:

(1) Immediately, if the increase is due to the inclusion of a previously excluded family member who has income.

(2) ~~For MFBUs with a one month share of cost period:~~ In accordance with the following, in all other instances:

(A) The first of the month following the month in which the change was reported, if a 10 day notice can be given.

(B) The first of the second month following the month in which the

change was reported, if the change cannot be made in accordance with (A).

~~(3)--For-MFBUs-with-a-multimonth-share-of-cost-period-and-the-change is-reported-during-the-last-month-of-a-share-of-cost-period:~~

~~(A)--The-first-month-of-the-following-share-of-cost-period,-if-a 10-day-notice-can-be-given.~~

~~(B)--The-second-month-of-the-following-share-of-cost-period,-if-the change-cannot-be-made-in-accordance-with-(A).~~

~~(4)--For-MFBUs-with-a-multimonth-share-of-cost-period-and-the-change is-reported-prior-to-the-last-month-of-the-share-of-cost-period:~~

~~(A)--The-first-of-the-month-within-the-share-of-cost-period-following the-issuance-of-a-10-day-notice.--The-share-of-cost-for-the-period-shall be-adjusted-in-accordance-with-(c).~~

~~(B)--The-first-month-of-the-following-share-of-cost-period,-if-the change-cannot-be-made-in-accordance-with-(A).~~

(b) (2) Determine what the share of cost should have been for the share ~~of-cost-periods~~ months in which the increase occurred.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(9) Amend Section 50657 (a) (2) through (4) to read as follows and renumber (a)(6), (7) and (8) to (a)(5), (6) and (7) respectively:

(2) Form MC 177S shall be issued to the beneficiary for each ~~period~~ month during which the beneficiary must meet a share of cost.

(A) For continuing beneficiaries, form MC 177S shall be issued prior to the first day of the month of ~~the-share-of-cost-period~~ eligibility.

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(B) For new and restored beneficiaries, form MC 177S shall be issued at the time the approval notice of action is issued.

~~(3)--An additional or supplemental form MC 177S shall be issued when the share of cost is increased during a share of cost period as specified in Section 50653.5.~~

~~(4)~~ (3) The beneficiary shall present form MC 177S to each provider when the cost of services provided will be used to meet the share of cost.

~~(5)~~ (4) The provider will list on the form MC 177S health services which have been provided and meet all of the following criteria:

(A) Were provided in the ~~period~~ month specified on form MC 177S. Services are considered to have been provided in the ~~period~~ month of the date of service is within the ~~period~~ month. The date of service for:

1. Health Services provided under a Global Billing Agreement is the date the last service under the agreement is rendered or the date of delivery, if the global billing is for pregnancy and delivery.

2. Dental prosthesis, prosthetic and orthotic appliances, and eye appliances is the date the item is actually ordered from the fabricating laboratory.

3. Prescription drugs is the date the item was actually received.

4. All other health services is the date the service was actually rendered.

(B) Have not been submitted as a claim against the Medi-Cal program.

(C) Have not been paid by medicare, other health care coverage, or any other party, and the provider does not anticipate reimbursement from such sources for the amounts listed on form MC 177S.

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NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

(10) Amend Section 50658 by amending subsection (a)(3) to read as follows and deleting subsection (a)(8).

(3) Each service listed was provided within the ~~period~~ month specified on the form.

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.



(11) Amend Section 50737(c) to read:

(c) The Medi-Cal card for persons who have met their share of cost and are required to complete form MC 177S, shall contain:

(1) The items listed in (b).

(2) The date of certification for claims clearance. ~~The date of certification shall be:~~

~~(A) For the month during the share of cost period in which the share of cost is met, the last date of service listed on form MC 177S.~~

~~(B) For any prior month during the share of cost period, the last day of that month.~~

~~(C) For any subsequent month during the share of cost period, the first day of that month providing the beneficiary remains eligible and certified.~~

NOTE: Authority cited: Sections 10725, 14005.9(c) and 14124.5, Welfare and Institutions Code.

Reference: Section 14005.9, Welfare and Institutions Code.

DO NOT WRITE IN THIS SPACE

## FINDING OF EMERGENCY

This agency certifies the attached orders are necessary for the immediate preservation of the public peace, health and safety or general welfare. The specific facts constituting the need for immediate action are:

## STATEMENT OF FACTS

These regulations implement, interpret and make specific Section 14019.9 of the Welfare and Institutions Code as amended by SB 1326, Chapter 327, Statutes of 1982 and SB 2012, Chapter 1594, Statutes of 1982.

Section 14005.9(c), Welfare and Institutions Code provides as follows:

> (c) The State Director of Health Services shall adopt regulations implementing this section as emergency regulations in accordance with the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted by the State Department of Health Services in order to implement the provisions shall not be subject to the review and approval of the Office of Administrative Law. These regulations shall become effective immediately upon filing with the Secretary of State.

## COST STATEMENT

A. Fiscal Effect on Local Government: None.

B. Fiscal Effect on State Government: Annual General Fund savings of approximately $627,550 (82/83 savings $516,400).

C. Fiscal Effect in Federal Funding of State Programs: Annual savings of approximately $627,450 (82/83 savings $328,700).

D. Fiscal Effect on Small Businesses: None.

# 12C - PROCESSING CASES WHEN A SHARE OF COST HAS BEEN REDUCED RETROACTIVELY

## A. Background

California Administrative Code (CAC), Title 22, Sections 50565 and 50567, discuss the options available to eligible persons determined, after recomputation, to have a lower Medi-Cal share of cost for a given month than was originally computed. Such a person has the option of:

1. Having future share-of-cost amounts adjusted by the county; or

2. Adjusting with providers, the amounts obligated or paid to those providers to meet the overstated portion of the original share of cost.

If an individual is seeking an adjustment of a future share of cost and transfers to another county prior to receiving the full adjustment, the former county of responsibility must inform the new county of the adjustment amount that is still due.

Beneficiaries whose future share of cost is zero before an adjustment is applied, must be advised that the only recourse is to seek reimbursement from the provider. In any situation where a beneficiary chooses to seek reimbursement from a provider, it must first be determined whether the provider has billed Medi-Cal for any portion of the service for which reimbursement is requested. This may be determined by reviewing the original MC 177. If the "Total Bill" amount is greater than the "Patient Billed" amount or if there is an amount shown in the "Billed Medi-Cal" column, it should be assumed that the provider has billed Medi-Cal. If the "Billed Medi-Cal" column is blank or the "Billed Patient" column is equal to the "Total Bill" column, it should be assumed that the provider has not previously billed the Medi-Cal program.

Prior to seeking reimbursement from the provider, clients shall be instructed by the county to give the provider a revised MC 177-S and a "Share of Cost Medi-Cal Provider Letter" (MC 1054 -- see Attachment II) so that the provider may bill the Medi-Cal program and reimburse the client the appropriate share-of-cost amount. If the county or the client is in possession of the original MC 177-S, the county may modify that form rather than prepare a revised one. The "Share of Cost Medi-Cal Provider Letter" will explain the reimbursement and billing procedures and the recomputation of the share of cost. So that the provider may be informed of the proper procedures to follow, counties shall check the box appropriate to the client's situation.

The MC 1054 may be ordered through the normal Department forms ordering process described in the forms section of the Medi-Cal Eligibility Manual, page F-1, beginning May 15, 1980. Until that time, the MC 1054 may be reproduced by the counties.

Individuals needing a Medi-Cal identification card in order to accomplish the adjustment process should be given proof of eligibility (POE) labels only, except for individuals who did not meet their original share of cost. Those beneficiaries who did not meet their original share of cost will receive a full complement card from Benefits Review Unit (BRU) when the MC 177 is completed and processed. If any individual used services to meet the share of cost which would require a "MEDI" label, the provider may use the POE label, along with the MC 1054 to bill the program. This letter will alert the fiscal intermediary (FI) that the case is being adjusted and to waive the "MEDI" label requirement for the specific services listed on the claim; in addition, a Treatment Authorization Request (TAR) will not be necessary for claims submitted with this letter for services normally requiring a TAR.

B. Case Situations

The following procedures describe the adjustment process and the different methods for working with various case situations in recomputing the share of cost.

Adjustment of Share-of-Cost Amount

Case Situation 1 -- Client was determined eligible for July with a share of cost and met the share of cost. It is later determined that the July share of cost should have been lower. Client requests adjustment of future share-of-cost amounts.

Case Processing Steps

a. The county shall recompute the July share of cost and prepare a new MC 176-M (latest revision) for the case file. (The difference between the original and recomputed share of cost for July is the amount of the adjustment.)

b. On the MC 176-M for August (the future month in which the share of cost is to be adjusted) enter the August share-of-cost amount in Column III, line 17, and enter the amount of the adjustment in line 18. Subtract line 18 from line 17 to determine the new adjusted share-of-cost amount (see example -- Attachment III) and enter the amount in line 19. If the amount of the adjustment (line 18) is greater than the August share-of-cost amount (line 17), the client is not required to meet a share of cost for August. If necessary, repeat this step for subsequent months until the entire adjustment is made.

c. For the August and other future months' eligibility, the county shall prepare an MC 177-S showing the adjusted share-of-cost amount and submit to the client (see example -- Attachment IV). The MC 177-S must be completed by the provider showing the amount of the new adjusted share of cost for which the client is responsible.

d. Upon completion of the MC 177-S by the provider, the client must sign and return the form to the county, which in turn, shall send it along with the revised MC 176-M to: Department of Health Services, Benefits Review Unit, P. O. Box 668, Sacramento, CA 95803, for card issuance.

Case Situation 2 -- Client was determined eligible for October with a share of cost, but did not meet the share-of-cost amount in full. It is later determined that the October share of cost should have been lower. Client requests adjustment of the future share of cost.

Case Processing Steps

a. Obtain documentation from the client of the amount that was paid or obligated toward services received in October (documentation may be cancelled checks, a statement of charges from the provider, or the original MC 177-S for October showing amounts paid or obligated to the provider). If no documentation exists, the client may choose to have the provider complete a new MC 177-S.

b. If it is determined that the client paid or obligated more than the recomputed October share of cost, the difference between the amount paid or obligated and the recomputed share of cost will be the amount to be adjusted (e.g., client's original share of cost is $100.00, client paid $75.00; the recomputed share of cost is $50.00, the amount to be adjusted for future months is $25.00).

c. Process case according to steps listed for items a-d in Case Situation 1. The client should be provided a new MC 177-S for each month in question, indicating the adjusted share of cost.

d. If the amount already paid or obligated in October is less than the recomputed October share of cost, no adjustment is necessary.

Provider Reimbursement of Share-of-Cost Amount

Case Situation 3 -- Client was determined eligible in November with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been zero. Client wants a reimbursement of the share-of-cost amount paid to the provider(s). The provider(s) billed Medi-Cal for a portion of the service(s).

Case Processing Steps

a. The county shall recompute the November share of cost and prepare the MC 176-M for the case file.

b. The county shall also prepare an MC 1054 explaining the November share-of-cost adjustment, give it to the client, and send a copy to BRU for its record.

c. The client should give the MC 1054 to the provider.

d. The provider should then submit a claim along with a copy of the MC 1054 to the appropriate Medi-Cal FI.

e. The FI will reimburse the provider the appropriate adjusted amount.

f. The provider(s) should then pass the difference in the share-of-cost amount on to the client.

Case Situation 4 -- Client was determined eligible in September with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been lower. Client wants reimbursement for the excess share-of-cost amount paid. The provider(s) billed Medi-Cal for a portion of the service(s).

Case Processing Steps

a. The county shall recompute the September share of cost and prepare the MC 176-M for the case file.

b. The county shall also prepare a revised MC 177-S showing the recomputed September share-of-cost amount and give it to the client along with a completed copy of the MC 1054.

c. The client should submit to the provider form MC 177-S and the MC 1054 which explain the adjustments made.

d. Upon completion of the MC 177-S by the provider, the client must sign and return the form to the county.

e. The county will send form MC 177-S and a copy of the recomputed MC 176-M to Department of Health Services, BRU.

f. BRU will adjust any previous claims submitted by the providers and return the claims to the FI.

g. The FI will reimburse the provider the appropriate amount.

h. Provider(s) should then pass the difference in the share-of-cost amount on to the client.

Case Situation 5 -- Client was determined eligible in January to have a share of cost and met the share of cost. A recomputation indicates the share of cost should have been lower. Client wants a reimbursement of the excess share-of-cost amount previously paid. Client's provider(s) did not previously bill the Medi-Cal program.

Case Processing Steps

a. For processing MC forms 176-M and 177-S, follow steps a-e in Case Situation 4.

b. BRU will request preparation of a Medi-Cal card with POE labels only. The card will be mailed directly to the client by the Department of Health Services.

c. The client should return the POE labels to the provider who should reimburse the client and use the labels to bill the program.

Case Situation 6 -- Client was determined eligible in June with a share of cost and met the share of cost. A recomputation indicates the share of cost should have been zero. Client wants a reimbursement of the share-of-cost amount paid to the provider(s). The provider(s) did not previously bill the Medi-Cal program.

Case Processing Steps

a. The county shall recompute the June share of cost, prepare the MC 176-M for the case file, and send a copy to BRU for its records.

b. The county shall prepare for the client the MC 1054 explaining the June share-of-cost adjustment and issue the client a POE only Medi-Cal card or request that one be issued by BRU via form MC 110.

c. The client should present the Medi-Cal card and the MC 1054 to the provider.

d. The provider should then submit a claim with the Medi-Cal label attached along with a copy of this letter to the Medi-Cal FI.

e. The FI will reimburse the provider the appropriate amount.

f. The provider(s) should then pass the difference in the share-of-cost amount on to the client.

C. Submitting Revised MC 176-M and MC 177-S Forms to Department of Health Services

In order to ensure proper processing of recomputed share-of-cost cases by BRU, it will be necessary for county welfare departments to properly identify these cases. The following procedures shall be followed:

1. In case situations where the provider has billed the Medi-Cal program previously and the client still, after recomputation, has a share of cost and does not want a reimbursement, counties shall indicate at the top of the revised MC 177-S "Adjustment -- Billed" (see Attachment IV).

2. In case situations where the provider has billed the Medi-Cal program and the client, after recomputation, has a lower share of cost and wants a reimbursement, the county shall indicate on the top of the revised MC 177-S "Adjust Previous Claims" (see Attachment V).

3. In case situations where the client met the share of cost and the provider did not bill the program because the share of cost equaled the amount of the bill and the client, after recomputation, has a lower share of cost, the county shall indicate at the top of the MC 177-S -- "Adjustment -- Not Billed" (see Attachment VI). For these cases, BRU will prepare a Medi-Cal identification card, POE labels only, and mail it directly to the beneficiary.

4. In case situations where the client met the share of cost, the recomputed share of cost is zero and the provider did not previously bill the program, the county shall indicate at the top of the MC 176-M -- "Adjustment -- Not Billed Zero Share of Cost". If requested by the county, BRU will prepare a Medi-Cal card, POE labels only, and mail it directly to the beneficiary.

5. In case situations where the client did not meet the original share of cost in part or in full, and the client still, after recomputation, has a share of cost, the county shall process the case using the current MC 177-S procedures described in Section 12A of the Medi-Cal Eligibility Manual. When the MC 177-S is received by BRU, a full complement Medi-Cal identification card will be issued and sent directly to the beneficiary.

County welfare departments must "batch" the MC 177-S forms separately for each of the specific case situations described. These "batches" should not be combined with regular share-of-cost cases being sent to BRU except for those cases described in number 5 above. To expedite processing of recomputed share-of-cost cases and to ensure proper processing, it is extremely important that these procedures be followed.

ATTACHMENT I

# ADJUSTMENTS OF SHARE OF COST AND PROVIDER REIMBURSEMENT

## Summary Chart

| Case Situation | Case Processing | | | | |
|---|---|---|---|---|---|
| | Prepare new 176 for case file and/or BRU | Prepare 177 for provider completion | Give "Share of Cost Medi-Cal Provider Letter" form MC 1054 to provider | Send 177/176 to BRU | County or BRU preparation of Medi-Cal ID card |
| 1. Client met original share of cost. Share of cost should be lower. Client requests adjustment of future share-of-cost amounts. | X | X | | X | |
| 2. Client did not meet original share of cost. Share of cost should be lower. Client requests adjustment of share-of-cost amount. | X | X | | X | |
| 3. Client met original share of cost. Share of cost should have been zero. Provider(s) billed Medi-Cal. Client requests reimbursement from provider. | X | | X | X | |

ADJUSTMENTS OF SHARE OF COST
AND PROVIDER REIMBURSEMENT

Summary Chart

| Case Situation | Case Processing | | | | |
|---|---|---|---|---|---|
| | Prepare new 176 for case file and/or BRU | Prepare 177 for provider completion | Give "Share of Cost Medi-Cal Provider Letter" form MC 1054 to provider | Send 177/176 to BRU | County or BRU preparation of Medi-Cal ID card |
| 4. Client met original share of cost. Share of cost should have been lower. Provider(s) billed Medi-Cal. Client requests reimbursement from provider. | X | X | X | X | |
| 5. Client met original share of cost. Share of cost should have been lower. Provider(s) did not bill Medi-Cal. Client requests reimbursement from provider. | X | X | X | X | X (POE labels only) |
| 6. Client met original share of cost. Share of cost should have been zero. Provider(s) did not bill Medi-Cal. Client requests reimbursement from provider. | X | | X | X | X (POE labels only) |

(Provider Address)

(County Address)

RE: _____

The individual(s) shown above had been determined eligible for Medi-Cal for the month(s) of _____ with a monthly share of cost of _____. Upon review, it has been determined that the share of cost for the month(s) indicated should have been only _____. Accordingly, the beneficiary is due a reimbursement of the difference between the share-of-cost amount paid to you and the recomputed share of cost. This amount must be passed along to the beneficiary by the provider in accordance with California Administrative Code, Title 22, Section 51471.1. The following information is to assist you in making the required reimbursement.

If the beneficiary actually paid the original share-of-cost amount to you and you billed Medi-Cal for the balance of the charges, you may be eligible to receive an adjustment from the Medi-Cal fiscal intermediary. Once you have billed the program, you are obligated to pay the beneficiary the excess share-of-cost amount previously paid to you.

If the beneficiary actually paid the original share-of-cost amount to you, and you did not bill the program because the charges equaled the original share-of-cost amount, you may now bill the program for the difference between your usual fee and the recomputed share of cost. Again, you are obligated to pay the beneficiary the excess share-of-cost amount previously paid to you.

If the beneficiary has not paid, but obligated to pay the original share of cost, the new adjusted amount should be used to reduce the obligation.

If you were unable to bill the program because the beneficiary has not paid or obligated the full amount of the original share of cost, you may now do so by submitting this form and a claim with a Medi-Cal label to the Medi-Cal fiscal intermediary.

The items checked below must be accomplished in order to complete the reimbursement process.

☐ Complete the MC 177S based on the revised share-of-cost amount. If the beneficiary meets the recomputed share of cost, he/she will be issued a Medi-Cal card. Any outstanding balance may be billed to Medi-Cal.

☐ It is not necessary for you to rebill the Medi-Cal program for the services listed on the MC 177S. An adjustment to your previous claim will be made by the Department of Health Services.

☐ It will be necessary for you to bill the Medi-Cal program. You must attach this form letter to your claim. The beneficiary listed above is responsible for presenting you with a Medi-Cal identification card or label to attach to your claim. If you are billing the Medi-Cal program and you rendered a service requiring a MEDI label or "prior authorization", this form, along with the Medi-Cal identification card (POE) label attached to your claim, will allow the fiscal intermediary to process the claim without those items.

_____

Eligibility Worker's Signature

_____

Eligibility Worker's Phone Number

SHARE OF COST DETERMINATION—MN AND MI PERSONS

ATTACHMENT III

CASE NAME

COUNTY DISTRICT | COUNTY USE

☐ NEW APPLICATION ☐ REDETERMINATION ☐ CHANGE ☐ RETROACTIVE ELIG. ☒ CORRECTION

EFFECTIVE ELIGIBILITY DATE FOR THIS BUDGET MO. YR.

| State Number Co. | Aid | 7 Digit Serial No. | MFBU | Pers. No. | Name — First, Middle, Last | Birthdate Mo. Day Yr. | Sex | (1) Social Security No. and (2) Health Insurance Claim No. or Railroad Retirement No. | Other Coverage |
|---|---|---|---|---|---|---|---|---|---|
| 23 | 14 | 00000000 | 0 | 50 | Helen Of Troy | 1/20/19 | F | (1) 543-16-0000 (2) | A |
| 23 | 14 | 00000000 | 0 | 60 | William Of Troy | 7/5/13 | M | (1) 561-42-0000 (2) | A |
| | | | | | | | | (1) (2) | |
| | | | | | | | | (1) (2) | |
| | | | | | | | | (1) (2) | |
| | | | | | | | | (1) (2) | |
| | | | | | | | | (1) (2) | |

## I. INCOME OF MFBU MEMBERS APPLYING AS AGED, BLIND, OR DISABLED PLUS INCOME OF SPOUSE OR PARENT (EXCEPT PA OR OTHER PA)

### A. NONEXEMPT UNEARNED INCOME

| | a. ABD - MN | b. Spouse or parent |
|---|---|---|
| 1. Social Security | | |
| 2. Net income from Property | | |
| 3. Other — itemize | | |
| 4. | | |
| 5. through 4) | | |
| 6. Deductions | | |
| 7. Remainder (5 minus 6) | a. | b. |
| 8. Combined unearned inc. (add 7a and 7b) | | |
| 9. Any income deduction | —$20 | |
| 10. Countable unearned income (8 minus 9) | | |

### B. NONEXEMPT EARNED INCOME

| | a. | b. |
|---|---|---|
| 11. Gross Earned Income | | 1,500 |
| 12. Deductions | | 75 |
| 13. Remainder (11 minus 12) | a. | b. 1425 |
| 14. Combined earned inc. (add 13a and 13b) | | |
| 15. $65 earned inc. deduction plus $_____ unused $20 | | 85 |
| 16. Remainder (14 minus 15) | | 1340 |
| 17. Countable earned inc. (divide 16 by 2) | | 670 |
| 18. Total countable inc. (add 10 and 17) | | 670 |

### V. EXEMPT INCOME

## II. INCOME OF MFBU MEMBERS OR PERSONS RESPONSIBLE FOR THE MFBU NOT LISTED IN I. (EXCEPT PA OR OTHER PA)

### A. NONEXEMPT UNEARNED INCOME

| | |
|---|---|
| 1. Social Security | |
| 2. Net income from property | |
| 3. Other—itemize | |
| 4. | |
| 5. Total unearned inc. (add 1 through 4) | |
| 6. Deductions | |
| 7. Countable unearned inc. (5 minus 6) | |

### B. NONEXEMPT EARNED INCOME

| | |
|---|---|
| 8. Gross earned inc. | |
| 9. If GG in last 4 months a. enter $30 | |
| b. ⅓ Remainder | |
| 10. Mand. deduct. | |
| 11. W/R expenses | |
| 12. Total earned inc. deductions (add 9, 10, 11) | |
| 13. Countable earned inc. (8 minus 12) | |
| 14. Total countable inc. (add 7 and 13) | |

## III. SHARE OF COST COMPUTATION

| | |
|---|---|
| 1. Countable income from I 18 | |
| 2. Countable income from II 14 | |
| 3. Combined countable income (add 1 and 2) | 670 |

### ALLOCATIONS AND DEDUCTIONS

| | |
|---|---|
| 4. Inc. allocated from LTC person to family members at home (176W, Part IV) | |
| 5. Total countable income (add 3 and 4) | 670 |
| 5. Allocation from LTC income (176W, Part IV) | |
| 7. Allocation to stepparent unit (176W, Part V) | |
| 8. Allocation to excluded family members (176W, Part I) | |
| 9. Special deduction (176W, Part II) | |
| 10. Income to determine PA eligibility | |
| 11. Health insurance | |
| 12. Child support | |
| 13. Total allocations/deductions (add 6 through 12) | |
| 14. Total net nonexempt income (5 minus 13) | 670 |
| 15. Total net nonexempt income rounded | |
| 16. Maintenance need | |
| a. MFBU members not in LTC No. 2 | 544 |
| b. MFBU members in LTC • Personal needs • Upkeep of home • Needs of disabled dependents | |
| c. Total maintenance need (16a + 16b) | 544 |
| 17. Share of cost (15 minus 16) | 189 |
| 18. Underpayment adjustment | 116 |
| 19. Adjusted share of cost (17 minus 18) | 73 |

ELIGIBILITY WORKER SIGNATURE

WORKER NUMBER 1484567

DATE OF COMPUTATION | COUNTY USE 1484567

MC 176 M (4-79)

Sections 50565, 50567 MANUAL LETTER NO. 12C-11

ATTACHMENT IV

State of California—Health and Welfare Agency "ADJUSTMENT BILLED"
Medi-Cal Program

Department of Health

| CO DIST | COUNTY USE |
|---|---|
| 23 | 1484567 |

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

| Only Medical expenses in the following month may be listed below. | Share of Cost The amount that you must pay or obligate is: | Page of |
|---|---|---|
| 10/73 Mo. Yr. | $ 42.00 | Retro. Elig? No (Yes/No) |

Name: Helen Of Troy
Address: 12345 Greek Street
City/State/Zip: Peanutville, Ca 55555

County Code: 23

Medical expenses of family members listed below may be used to meet Share of Cost

| State Number | | | | Name — Last, First | B | A | Birthdate Mo. Day Yr. | Sex | Other Cov. Code | Social Security No. | HIC or RR No. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Aid | 7 Digit Serial No. | FBU | Pers. | | | | | | | | |
| 14 | 0000000 | 0 | 60 | Troy, William Of | | | 7/5/13 | M | A | 561-42-0000 | |
| 84 | 0000000 | 0 | 50 | Troy, Helen Of | | | 1/20/19 | F | A | 543-16-0000 | |

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I recall payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or other third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

| PROVIDER NAME | Provider No. | Date of Service Mo. | Day | Yr. | SERVICE | Proc. Code/ Presc. No. | Total Bill $ | Billed Patient $ | Billed Medi-Cal $ |
|---|---|---|---|---|---|---|---|---|---|
| Ronald Reagan | XYA 777 | | | | | | | | |
| PATIENT NAME: William Of Troy | | 10 | 5 | 79 | Surgery | 8524 | 942 | 42 | 900 |
| PROVIDER SIGNATURE (See Declaration Above) | | | | | | | | | |
| PROVIDER NAME | Provider No. | | | | | | | | |
| PATIENT NAME | | | | | | | | | |
| PROVIDER SIGNATURE (See Declaration Above) | | | | | | | | | |
| PROVIDER NAME | Provider No. | | | | | | | | |
| PATIENT NAME | | | | | | | | | |
| PROVIDER SIGNATURE (See Declaration Above) | | | | | | | | | |
| PROVIDER NAME | Provider No. | | | | | | | | |
| PATIENT NAME | | | | | | | | | |
| PROVIDER SIGNATURE (See Declaration Above) | | | | | | | | | |

STATE USE ONLY

| Mo. | Day | Yr. | Reviewed By: | Trans. | Replace |
|---|---|---|---|---|---|
| 10 | 5 | 78 | | | |

Date of Certification

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

X William Of Troy
SIGNATURE OF APPLICANT DATE

MC 177—S (1/72)

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING.

12C-12

Sections 50565, 50567

MANUAL LETTER NO.

State of California—Health and Welfare Agency
Medi-Cal Program

"ADJUST PREVIOUS CLAIMS"

ATTACHMENT V

Department of Health

RECORD OF HEALTH CARE COSTS – SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

| CO DIST | COUNTY USE |
|---|---|
| 23 | 1484567 |

| Only Medical expenses in the following month may be listed below. | Share of Cost: The amount that you must pay or obligate is: | Page of / Retro. Elig? |
|---|---|---|
| 10/73 (Mo. Yr.) | $ 42.00 | No (Yes/No) |

Name: Helen Of Troy
Address: 12345 Greek Street
City/State/Zip: Peanutville, Ca 55555

County Code: 23

Medical expenses of family members listed below may be used to meet Share of Cost

| State Number: Aid | 7 Digit Serial No. | FBU | Pers. | Name — Last, First | B | A | Birthdate Mo. Day Yr. | Sex | Other Cov. Code | Social Security No. | HIC or RR No. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | 0000000 | 0 | 60 | Troy, William Of | | | 7/5/13 | M | A | 561-42-0000 | |
| 84 | 0000000 | 0 | 50 | Troy, Helen Of | | | 1/20/19 | F | A | 543-16-0000 | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I received payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or other third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

| PROVIDER NAME / PATIENT NAME / PROVIDER SIGNATURE (See Declaration Above) | Provider No. | Date of Service Mo. | Day | Yr. | SERVICE | Proc. Code/ Presc. No. | Total Bill $ | Billed Patient $ | Billed Medi-Cal $ |
|---|---|---|---|---|---|---|---|---|---|
| Ronald Reacan / William Of Troy | XYA 777 | 10 | 5 | 79 | Surgery | 8524 | 942 | 42 | 900 |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

STATE USE ONLY

Date of Certification: Mo. 10 | Day 5 | Yr. 78

Reviewed By: | Trans. | Replace

I have read the instructions on the back of this form. I agree to assume full legal responsibility for the amounts listed above in the "Billed Patient" column.

X William Of Troy
SIGNATURE OF APPLICANT — DATE

MC 177—S (1/78)

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING.

Sections 50565, 50567 MANUAL LETTER NO. 12C-13

State of California—Health and Welfare Agency "ADJUSTMENT -- NOT BILLED"
Medi-Cal Program

ATTACEMENT VI
Department of Health

RECORD OF HEALTH CARE COSTS - SHARE OF COST

READ INSTRUCTIONS ON BACK BEFORE COMPLETING

| CO DIST | COUNTY USE |
|---|---|
| 23 | 1484567 |

| Only Medical expenses in the following month may be listed below. | Share of Cost The amount that you must pay or collate is: | Page of | Retro. Elig? |
|---|---|---|---|
| 10/73 Mo. Yr. | $ 42.00 | | No (Yes/No) |

Name: Helen Of Troy
Address: 12345 Greek Street
City/State/Zip: Peanutville, Ca 55555

| County Code |
|---|
| 23 |

Medical expenses of family members listed below may be used to meet Share of Cost

| State Number: Aid | State Number: 7 Digit Serial No. | State Number: FBU | State Number: Pers. | Name — Last, First | B | A | Birthdate Mo. Day Yr. | Sex | Other Cov. Code | Social Security No. | HIC or RR No. |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 14 | 0000000 | 0 | 60 | Troy, William Of | | | 2/5/13 | M | A | 561-42-0000 | |
| 84 | 0000000 | 0 | 50 | Troy, Helen Of | | | 1/20/19 | F | A | 543-16-0000 | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |

Declaration of Provider: Each service listed below has been provided to the person listed on the date specified. I, the undersigned provider, hereby declare that I receive payment or will seek payment from the patient for the amount shown in the "Billed Patient" column and that I will not accept payment from the Medi-Cal program for that amount. I also understand and agree that I may seek payment from the Medi-Cal program for the costs of my service in excess of the amount billed to the patient. This is the amount shown in the "Billed Medi-Cal" column, and is the difference between the "Total Bill" and amount "Billed Patient".

I understand that if I bill insurance or any other third party for the service rendered, I cannot list on this form the amount of the charge paid by the insurance or other third party.

I am aware that financial information on this form may be subject to scrutiny by the Internal Revenue Service and/or State Franchise Tax Board.

| PROVIDER NAME / PATIENT NAME / PROVIDER SIGNATURE (See Declaration Above) | Provider No. | Date of Service Mo. | Day | Yr. | SERVICE | Proc. Code/ Presc. No. | Total Bill $ | Billed Patient $ | Billed Medi-Cal $ |
|---|---|---|---|---|---|---|---|---|---|
| Ronald Reacan / William Of Troy / | XXA 777 | 10 | 5 | 79 | Surgery | 8524 | 042 | 42 | 900 |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

STATE USE ONLY

| Mo. | Day | Yr. | Reviewed By: | Trans. | Replace |
|---|---|---|---|---|---|
| 10 | 5 | 78 | | | |

Date of Certification

I have read the [illegible] on the back of this form, agree to assume full legal responsibility for the amounts listed [illegible] Billed Patient column.

X William Of Troy 8/30/79
SIGNATURE OF APPLICANT DATE

MC 177—5 (1/74)

READ INSTRUCTIONS ON BACK OF THIS FORM BEFORE COMPLETING.

Sections 50565, 50567 MANUAL LETTER NO. 12C-14